MASSACHUSETTS

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March 3, 2010

David Morales, Commissioner
Massachusetts Division of Health Care Finance and Policy
Two Boylston Street, 5th Floor
Boston, MA 02216

RE: *Responses to Questions from Division of Health Care Finance and Policy and Attorney General*

Dear Commissioner Morales:

On behalf of Blue Cross and Blue Shield of Massachusetts (BCBSMA), we are pleased to provide the following responses to the Division of Health Care Finance and Policy (the Division) and Attorney General's questions posed in Attachments B and C respectively in a letter from Commissioner Morales dated February 12, 2010.

Below are detailed responses to the Division's and the Attorney General's questions.

Division of Health Care Finance and Policy (DHCFP) Questions

1) After reviewing the preliminary reports located at www.mass.gov/dhcfp/costtrends please provide commentary on any data, or finding that differs from your organization's experience and the potential reasons therefore.

BCBSMA Response:

The findings highlighted in the preliminary cost trend reports issued by DHCFP are consistent with BCBSMA experience.

Additionally, we would like to highlight other drivers of increasing medical expenses such as:

a. Market Reform: Health care reform mandated the merger of the individual and small group segments in Massachusetts effective July 2007. The individual segment has claims experience and trends that are significantly higher than the group business, due to higher morbidity and unfavorable selection in this segment. This has resulted in increasing per member per month annual trends across all services for the merged small group and individual segment by 4-5% and for the entire commercial group business by approximately 1-2%.

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b. Overuse of medical services: examples include increased rates of hospital admissions and emergency room visits for avoidable or ambulatory sensitive conditions and preventable readmissions.

c. Regulatory and legislative actions that impact costs and trends like mandates and assessments on insurers. One example of recently implemented mandates that resulted in increased cost is the expansion of federal mental health parity.

d. Environmental factors including but not limited to pandemics like the H1N1 outbreak and the economic downturn.

Questions Regarding Premium Pricing and Market Sector Differences

2) What were the differences by market sector in general administrative expenses built into your pricing from 2008 to the present? What portion of the differential by group size was attributable to fixed costs being spread over different group sizes? To what was the remainder of the difference attributable?

BCBSMA Response:

Administrative expenses are typically higher as a percentage of premium and on a pmpm basis for small group health insurance products than for large group products. Administrative expenses are generally allocated by group size based on per member and per account costs. Any fixed expenses or per account administrative expenses such as insurer overhead costs or the initial policy entry into the insurer's administrative systems, can be spread over more insured lives in a large group policy than in a small group policy. Furthermore, small group markets also incur expenses not typically incurred in the large group market. For instance, agent and broker expenses included in the premiums for individual and small group market plans are typically provided directly by consultants and human resources staff for large group plans, and therefore not included in premiums.

The total administrative expenses for Blue Cross Blue Shield of Massachusetts are allocated among the following major business segments: Commercial Medical, Medicare Supplement, Medicare Advantage, Dental, Federal Employee Health Plan, Reinsurance, and other small lines of business. The costs specific to each of these segments are identified based on resources required to support these segments. Consistent with market practice, administrative expenses for Commercial business are further allocated by group size based on per member and per account cost. This allocation methodology allows us to more accurately reflect the underlying costs associated with different group sizes.

Administrative expenses represent approximately 10 percent of total premium. For 2010 renewals to date, the general administrative expense for small groups, on a per member basis, was higher by approximately 4 percent of premium, than the expense for mid-size groups and large groups, due to the impact of fixed expenses being spread over a smaller number of members per account and the impact of broker commissions, which are predominantly incurred by smaller accounts. Approximately

60 percent of the difference in administrative expenses, or 2.5 percent of small group premiums, is due to fixed costs being spread over different group sizes.

A study of the administrative expenses in 2009 resulted in a refinement of the administrative expense allocation by size built into pricing. Prior to this analysis, the difference in administrative expenses by size was larger.

3) We found that, when adjusted for differences in benefits and demographics, small employers are being charged higher premiums and are experiencing a greater growth in premiums than mid-sized and large firms. Is this finding consistent with your health plan's experience? Please comment on why you think this is happening and what can be done to assist small employers.

BCBSMA Response:

This observation is consistent with BCBSMA experience.

Premiums for small groups and large groups are based on separate pools with different underlying characteristics.

In most markets, medical costs and trends for small groups versus mid-sized and large groups are higher. Most of the difference in adjusted premium levels for small groups versus mid-sized and large groups is due to differences in medical spending. Trends in per member per month costs for small groups are higher than trends in the large group segment.

Reasons for differences in cost and trend for small vs. large groups include the following:

- Adverse Selection: As cited in the recent Issue Brief published by the American Academy of Actuaries on risk pooling, a single large employer group is much more stable and less prone to adverse selection as compared to several small groups that are combined into one large pool since there is no guarantee as to which small groups will leave the pool at any given time. Additionally, large employer groups generally have controls in place to limit anti-selection like annual open enrollment periods, limited choice of benefit plans, premium contributions and eligibility based on employment with employer.
- Regulatory and Legislative impact: In the larger account and self-insured markets, there is flexibility in benefit selection. For example, self-insured accounts can carve out benefits to offer cost savings that would not be realized for smaller sized risks under current law.
- Geographic Location: Larger accounts tend to have multi-state populations where the cost structures and trends tend to be lower.
- Employer Incentives: HSA and HRA programs along with healthy behavior programs are often encouraged and funded by employers of larger groups to reward and encourage behaviors that will lead to lower trends in the long run.

Specific to MA and BCBSMA, additional drivers of this difference include:

- Health Care Reform and the merged market did not impact large group claims and trends. The impact of pooling the individual (Direct Pay) experience was spread over the small group market only. This resulted in a 4-5 percent increase in small group per member per month trends after Health Care Reform, primarily driven by increased morbidity and adverse selection in the individual (Direct Pay) segment.

The major reasons for the higher individual claim costs are:

- Individuals have higher medical costs and higher prevalence of disease as compared to group members;
- Some individuals are enrolling on a short-term basis for acute care rather than continuing coverage throughout the year; and
- Improper practices by certain entities who may be carving out sicker employees from self-funded group coverage and improperly directing them to individual products in the merged market.

In order to mitigate the impact of the merged market on the small group premiums, it is important to limit the impact of adverse selection and to encourage the healthy population to purchase insurance.

Under the category of limiting anti selection, we suggest the following:

- Stricter enrollment policies like annual open enrollment periods, waiting periods, premium penalties and coverage exclusions for individuals purchasing insurance for limited periods.
- Strengthening the individual mandate with corresponding penalties for non-compliance and assessing the penalty on an annual basis rather than prorating on a monthly basis, with exceptions allowed for those who legitimately cannot afford insurance as opposed to those who may be "gaming" the system.
- Prohibiting practices of new market entrants who may be pushing sicker individuals out of self-funded employer group coverage and improperly directing them to individual products in the merged market.

To help encourage more of the healthy population to buy insurance, we suggest the following be considered to allow for more affordable product offerings:

- Allowing more rating flexibility to reward healthy behaviors. More specifically, we believe the smoking and wellness factors, that are allowable rating factors in the small group regulations, should be applied outside the 2:1 rate bands. This will allow applicable small group employers to get the full impact of these factors.
- Providing lower cost options by continuing consideration of the effect of mandated benefits on the overall marketplace.
- Loosening geographic access requirements so that new and innovative provider networks can be developed.
- Creation of a mandatory high risk pool or reinsurance mechanism to fund the added cost of high risk/cost individuals.

4) We also found that most of the difference in adjusted premium levels for small group vs. mid-size and large group was due to differences in medical spending rather than retention. Is this finding consistent with your health plan's experience? Please comment on why you think this is happening and what can be done to assist small employers.

BCBSMA Response:

BCBSMA agrees with DHCFP findings that most of the premium differences between small and large group premiums was due to differences in medical spending rather than retention. Approximately 90 cents of every premium dollar is used to purchase health care services on behalf of our members.

Premiums for small groups and large groups are based on separate pools with different underlying characteristics.

In most markets, medical costs and trends for small groups versus mid-sized and large groups are higher. Most of the difference in adjusted premium levels for small groups versus mid-sized and large groups is due to differences in medical spending. Trends in per member per month costs for small groups are higher than trends in the large group segment.

Reasons for differences in cost and trend for small vs. large groups include the following:

- Adverse Selection: As cited in the recent Issue Brief published by the American Academy of Actuaries on risk pooling, a single large employer group is much more stable and less prone to adverse selection as compared to several small groups that are combined into one large pool since there is no guarantee as to which small groups will leave the pool at any given time. Additionally, large employer groups generally have controls in place to limit anti-selection like annual open enrollment periods, limited choice of benefit plans, premium contributions and eligibility based on employment with employer. Individual selection was also involved in employees' decision to purchase insurance.
- Regulatory and Legislative impact: In the larger account and self-insured markets, there is flexibility in benefit selection. For example, self-insured accounts can carve out benefits to offer cost savings that would not be realized for smaller sized risks under current law.
- Geographic Location: Larger accounts tend to have multi-state populations where the cost structures and trends tend to be lower.
- Employer Incentives: HSA and HRA programs along with healthy behavior programs are often encouraged and funded by employers of larger groups to reward and encourage behaviors that will lead to lower trends in the long run.

Specific to MA and BCBSMA, additional drivers of this difference include:

- Health Care Reform and the merged market did not impact large group claims and trends. The impact of pooling the individual (Direct Pay) experience was spread over the small group market only. This resulted in a 4-5% increase in small group per member per month trends after Health Care Reform, primarily driven by increased morbidity and anti-selection in the individual (Direct Pay) segment.

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- Some individuals are enrolling on a short-term basis for acute care rather than continuing coverage throughout the year; and
- Improper practices by certain entities who may be carving out sicker employees from self-funded group coverage and improperly directing them to individual products in the merged market.

In order to mitigate the impact of the merged market on the small group premiums, it is important to limit the impact of anti-selection and to encourage the healthy population to purchase insurance.

Under the category of limiting anti-selection, we suggest the following:

- Stricter enrollment policies like annual open enrollment periods, waiting periods, premium penalties and coverage exclusions for individuals purchasing insurance for limited periods.
- Strengthening the individual mandate with corresponding penalties for non-compliance and assessing the penalty on an annual basis rather than prorating on a monthly basis, with exceptions allowed for those who legitimately cannot afford insurance as opposed to those who may be "gaming" the system.
- Prohibiting practices of new market entrants who may be pushing sicker individuals out of self-funded employer group coverage and improperly directing them to individual products in the merged market.

To help encourage more of the healthy population to buy insurance, we suggest the following to allow for more affordable product offerings:

- Allowing more rating flexibility to reward healthy behaviors. More specifically we believe the smoking and wellness factors, that are allowable rating factors in the small group regulations, should be applied outside the 2:1 rate bands. This will allow applicable small group employers to get the full impact of these factors.
- Providing lower cost options by continuing consideration of the effect of mandated benefits on the overall marketplace.
- Loosening geographic access requirements so that new and innovative provider networks can be developed.
- Creation of a mandatory high risk pool or reinsurance mechanism to fund the added cost of high risk/cost individuals.

5) Small firms (with fewer than 51 employees) frequently indicate receipt of double digit premium increases even though our analysis shows the average premium PMPM increase for the small group market during the period studied to be below 10%. Please provide the distribution of premium increases for small employers renewing in 2008 and 2009 that were quoted assuming that no benefit changes would be made by the employer.

BCBSMA Response:

The less-than-10 percent average premium pmpm increase for the small group market observed by DHCFP incorporates the impact of small firms reducing benefits year over year.

As noted in the DHCFP cost trend report on Massachusetts Private Health Insurance Premium Trends, average premium pmpm data may not represent premium volatility for any specific employer group. Premiums for a specific small employer group may vary from the average due to changes in account characteristics and permissible rating factors including age, geographic location, benefit levels, participation, account size and industry.

The table below summarizes the distribution of premium increases for small employers that purchased health insurance benefits from BCBSMA renewing in 2008 and 2009 that were quoted assuming no change in benefit design.

	2008-2009 renewals	
Rate increase range (assuming no change in bft)	% of MM	% of groups
<=10%	39%	35%
(10% - 20%]	39%	42%
(20% - 30%]	15%	14%
(30% - 40%]	4%	5%
> 40%	3%	4%
Grand Total	100%	100%

Population considered here includes Individuals.

6) We understand that premiums for any given effective date are set prospectively based on claims experience from approximately a year and a half earlier. How well have your estimates matched actuals in 2006-2009? Do you see increasing volatility in claims costs, or prices/utilization rising more quickly than anticipated?

BCBSMA Response:

Base rates are developed on a quarterly basis at BCBSMA, with monthly trend factors applied to the base rates for the months within the quarter. For example, base rates for January, February and March would be developed through the same rate review process with February rates reflecting 1 month of trend relative to January and March rates reflecting 2 months of trend relative to January.

As part of the quarterly rate review process we analyze claim trends by market segment and in total. In order to reduce the volatility inherent in market segment specific claim trends, total book of business trends are used in the rating process to project fee for service claims. As a result of this, the variance between pricing estimates and actual claims can vary significantly by market segment.

The table below summarizes the variance between the pricing estimates and actual fee for service claims across all insured market segments and across the merged small group and individual market segment. A negative variance implies that the pricing estimates were higher than actuals. A positive variance indicates that pricing estimates were lower than actuals. Please note that for the small group/individual market segment, actual trends emerged higher than pricing estimates in all time periods and the variance increased dramatically after the markets were merged.

Year	Variance relative to pricing all market segments	Variance relative to pricing Small group/individual segment
2006	0.4%	.5%
2007	-1.2%	.4%
2008	-0.9%	5.2%
2009	-0.6%	2.7%

Note: rating analyses for 4q07, 4q08, 4q09 and 2q10 were used to approximate the CY 2006, CY 2007, CY 2008 and CY 2009 estimates respectively.

Emerging trends are monitored routinely and compared to forecasted trends through the rating, financial planning and reserving processes, at varying levels of detail. Increasing volatility in utilization, provider mix and severity is driving the variance between pricing estimates and actual claims. The impact of the merged market which can be clearly seen in the small group data, H1N1 flu and underlying unfavorable economic conditions were some of the factors driving unfavorable variances in pricing assumptions versus actual trends.

Questions Regarding Trend Towards Self-insured

7) We have seen an increase in the percent of members enrolled in self-insured plans over the past few years. Please provide information on the size of the firms that are becoming self-insured. Does it differ from those firms that have traditionally self-insured? What rationale are employers providing for changing to self-insured plans?

BCBSMA Response:

There is likely a recent increase in the percentage of members covered by self insured plans simply because the recessionary economy has more significantly impacted payroll of small to mid market employers than payroll for large employers, recognizing that most large employers in Massachusetts already self-insure. Furthermore nearly all major employers in resilient industry sectors, providing medical coverage to millions of resident employees and their family members offer self insured medical plans. Major hospitals, universities, financial institutions, grocery chains, IT companies, labor health & welfare benefit trusts, many cities and towns, out of state headquartered retailers including Wal-Mart, Lowe's, and Home Depot offer self-insured medical plans to Massachusetts residents.

Recently some large employers in the 1,000 - 5,000 employee range switched from insured to self-insured financial arrangements. Most did so seeking greater flexibility in benefit design, ease of benefit administration across the country, the elimination of the state PPO premium tax and the elimination or softening of benefit mandates, and for the potential cost savings that becoming an ERISA plan, even after taking on the fiduciary risk, offers their firms. Most employers making the switch have also purchased stop loss coverage to mitigate their financial exposure.

All growth within the ASC segment during that time has consistently related to Accounts having 1,000 or more subscribers. For 2009 the growth was related to Accounts having more than 2,500 subscribers.

8) Please provider an overview of the reinsurance products that the newly self-insured employers purchase from your organization.

BCBSMA Response:

BCBSMA offers self-insured accounts the ability to purchase Stop Loss directly from BCBSMA.

Specific Stop Loss provides excess coverage on each individual after a predetermined deductible amount.

Aggregate Stop Loss covers total claims that exceed and overall expected level, called the Aggregate Attachment Point. The claims that would count towards the satisfaction of the Aggregate Attachment Point would be all eligible claims up to the Specific Deductible plus a corridor (typically 25%).

Specific Stop Loss can be purchased alone, but Aggregate stop loss must be purchased in combination with Specific Stop Loss.

9) We found that the growth in spending for health care services in self-insured and insured large groups was faster than that in small and mid-sized groups. We also found that these groups generally offered richer benefit packages and have had a

slower "buy-down" than the other markets. Has your organization found a similar trend? If so, to what can you attribute this trend? Are there other factors associated with this trend besides the cost sharing differences for members? Has this trend continued in 2009 and 2010?

BCBSMA Response:

BCBSMA also experienced faster growth in health care spending in self-insured and insured large groups as compared to small and mid-sized groups. Furthermore, consistent with findings in the DHCFP cost trend reports, BCBSMA self-funded and large insured groups generally offer richer benefit packages and have a slower benefit buy-down rate than the other markets.

Drivers of the slower rate of benefit buy-down in large insured groups and self-insured groups include but are not limited to, greater price sensitivity in the small group segment, more opportunity to customize benefits in the large and self-insured segments and more resources available to large groups to make changes to benefit systems quickly.

Some of the reasons for differences for higher cost and trend for small groups include the following:

- Adverse Selection: As cited in the recent Issue Brief published by the American Academy of Actuaries on risk pooling, a single large employer group is much more stable and less prone to adverse selection as compared to several small groups that are combined into one large pool since there is no guarantee as to which small groups will leave the pool at any given time. Additionally, large employer groups generally have controls in place to limit anti-selection like annual open enrollment periods, limited choice of benefit plans, premium contributions and eligibility based on employment with employer. Individual selection was also involved in employees' decision to purchase insurance.
- Regulatory and Legislative impact: In the larger account and self-insured markets, there is flexibility in benefit selection. For example, self insured accounts can carve out benefits to offer cost savings that would not be realized for smaller sized risks under current law.
- Geographic Location: Larger accounts tend to have multi state populations where the cost structures and trends tend to be lower.
- Employer Incentives: HSA and HRA programs along with healthy behavior programs are often encouraged and funded by employers of larger groups to reward and encourage behaviors that will lead to lower trends in the long run.

Specific to MA and BCBSMA, additional drivers of this difference include:

- Health Care Reform and the merged market did not impact large group claims and trends. The impact of pooling the individual (Direct Pay) experience was spread over the small group market only. This resulted in

a 4-5% increase in small group per member per month trends after Health care Reform, primarily driven by increased morbidity and anti-selection in the individual (Direct Pay) segment.

This trend has continued in recent periods as well.

Questions Regarding Claims Trends

10) We found that increased prices were the most important driver of health care costs. We were unable to determine how much of the price increase was because of higher negotiated base rates and how much was because of care being delivered in more expensive settings. What do you believe to be the relative contribution to price increases of this shift to more expensive locations? What solutions, if any, are you developing to address this trend?

BCBSMA Response:

The increase in unit costs (provider prices), before considering shifts in sites of service and provider mix, contributes approximately 50 percent to medical cost trend.

Health care costs and trends are also impacted by shifts in the sites where members receive medical services. This accounts for approximately 20 percent of medical cost trend. Examples include use of tertiary vs. community hospitals, emergency room visits versus doctor office visits, use of hospital based labs and radiology services versus free standing settings. The remaining approximately 25 percent of medical cost trend is due to increased utilization and severity of services.

BCBSMA is working to change the way we pay for health care service and reward the quality and efficiency – not quantity – of care our members receive. Our primary contracting model for addressing quality and affordability is the Alternative Quality Contract (AQC). The AQC combines two forms of payment: a global, or fixed, payment per patient adjusted for health status, which increases annually in line with inflation; and substantial performance incentives tied to the latest nationally accepted measures of quality, effectiveness, and patient experience of care.

This new contract model is an important component of BCBSMA's overall strategy to align payment reform, performance measurement, provider and member incentives, and increased transparency of cost and quality information to achieve the twin goals of improving the quality AND affordability of health care for our members, providers and employers.

In addition to the AQC, other performance based contracting models are in place for providers under fee-for-service arrangements. The Hospital Performance Incentive Program (HPIP) rewards hospitals that focus on high quality care, patient experience, process improvements, and an organizational commitment to quality care governed at the highest level of the organization. Similarly, the Primary Care Incentive Program (PCPIP) focuses on rewarding our Primary Care Providers for their commitment to ensuring high quality care at in an effective manner. This program offers potential for

added reimbursement through achieving specific outcomes targets for a provider's diabetic, hypertensive, and cardiovascular-diseased patients, improved preventative screening rates, improved chronic care management, use of generic prescribing, and utilization of lower cost lab providers.

We believe that encouraging consumer and employer engagement through innovative product design and increased transparency of cost will address the increase in cost trends as a result of care being provided in more expensive settings.

11) We found that expenditures on hospital outpatient facility services grew – both due to increases in prices and an increase in the volume of services. In examining your plan's experience, what have you found accounts for the growth of hospital outpatient facility prices per service? What accounts for the growth in utilization of outpatient hospital facility services? Do you foresee the same factors continuing to drive high growth in facility charges in future years? What might be done to mitigate this cost growth?

BCBSMA Response

Aggregate utilization and cost statistics for outpatient hospital services are not estimated by BCBSMA because utilization information is not always consistently reported among the types of service within the overall category of outpatient services. However, separate utilization, cost and total per member per month trends for specific services like laboratory, radiology, surgery and emergency department are analyzed.

Drivers of growth in facility prices per service include:

Unit cost increases: Increases in the cost per service paid to providers

Provider Mix/Site of Service: BCBSMA has observed that cost and utilization trends for laboratory/pathology/radiology/surgery services performed outside a hospital are lower than trends for the same services provided in a hospital. The data indicates that lab, radiology and some outpatient surgery services are shifting from less expensive free standing facilities to more expensive hospital settings driving up the cost for these services. As hospitals have expanded their services, there are more procedures being done on an outpatient basis. Academic Medical Centers (AMCs) have expanded their services into the community -- in some areas, partnering with community hospitals; in other areas, competing with them. Two examples illustrate how this issue has played out in our market. Complex cancer care treatment, which has long been a domain of academic medical centers, has expanded to the community hospital settings. AMCs have built partnerships with community hospitals to expand their services into those communities and provide cancer care services in a hospital outpatient setting. Also in our market, colonoscopies and endoscopies tend to be done in the outpatient hospital setting; in other markets, more of these procedures are done in provider offices or clinic settings not connected to the outpatient hospital setting. We believe that this extension of services and procedures into the community hospital outpatient setting will continue to drive growth in facility costs going forward.

Severity of Services and Utilization: In line with national trends, we have seen a migration of services and procedures from Inpatient to Outpatient settings.

Drivers of growth in utilization of outpatient facility services identified by BCBSMA include:

Over-utilization of services like emergency room visits for avoidable or ambulatory sensitive conditions emergency as well as diagnostic tests and surgeries.

Merged Market: Utilization trends after the implementation of health care reform increased as a result of the merger of the small group market with the individual market. The individual market has higher rates of morbidity and correspondingly uses more health care services.

Increased volume of services like additional screenings, increased cancer treatments, movement of procedures (i.e. cardiac and orthopedic) from the IP to the OP setting, increasing labs, increasing general radiology.
Unless initiatives are put in place to address the issues highlighted above, the same factors will continue to drive high growth in facility charges in future years.

Possible solutions to mitigate this cost include but are not limited to:

- Comprehensive Payment reform: moving to a global payment system where providers are rewarded based on the quality and efficiency of service they provide instead of the volume of services provided. In addition, looking at any acute-care hospital that is not reimbursed on a fee schedule basis is first priority. There are hospitals in the network who are still paid on a Payment Account Factor (PAF) for outpatient services. These payments are made on a percentage of billed charges rather than a statewide fee schedule. BCBSMA will look to convert these non-standard outpatient payment methodologies to a statewide fee schedule.

- Consumer and employer engagement through innovative product design and increased transparency of cost to allow consumers and providers to better understand the value of the health care services they are receiving and the impact that their purchasing decisions can have on health care costs and premiums.

- Regulatory and legislative solutions to address the adverse selection in the merged market including annual open enrollment periods, high risk pools or reinsurance mechanisms, and strengthening the individual mandate.

- Strengthening determination of need processes to limit supply growth.

- Utilization Management programs to ensure appropriate use of services.

12) By how much do the rates your organization pays vary when procedures are provided in hospital facilities rather than freestanding facilities or a physician's office? How do these rates correlate with underlying costs of these different providers?

BCBSMA Response

Free Standing facilities provide services predominately related to MRI and lab and to a less extent certain surgeries. Low tech radiology and CT scans are not available (except in very limited instances) in the free standing setting.

In examining 2008 and 2009 claims data for same day surgery, lab and high tech imaging services, we noted that for our HMO network, average payments to free standing providers are approximately 45- 55% of average payments to hospital providers for similar services. The highest cost provider can be as much 2.5-3 times the free standing rate.

BCBSMA does not have access to detailed provider cost data that allows us to compare cost across different types of providers.

13) The growth in imaging services continues to be an important factor in cost growth. What steps are you taking, if any, to reduce the growth rate in imaging services? Do you have different pre-authorization policies for imaging services done in an outpatient facility, freestanding facility and a physician's office? If so, please provide a brief description.

BCBSMA Response

BCBSMA agrees that imaging services are an important factor in overall cost.

BCBSMA has taken significant steps to manage this cost by partnering with American Imaging Management (AIM) which is a vendor that works with providers to ensure appropriate administration of imaging tests for our members. This program focuses on reducing the potential overuse and misuse of non-medically necessary high-technology imagining. Through this program, clinical experience and guidelines are used to determine appropriate use of imaging services. These guidelines are applied across all provider settings but enforced differently based on level of utilization; for example, providers with highest utilization have a higher level of clinical review. There are some exceptions to the AIM requirements for providers under different payment arrangements such as global payments.

Our high-tech imaging (e.g. CTA, MRI/MRA, nuclear cardiac study, and PET scan) utilization trends have been decreasing over the past few years. However, the primary reason for the overall increase in imaging cost is unit price differences based on where imaging procedures are performed. Certain imaging services such as MRI can cost 50 percent more when performed in a hospital outpatient setting versus an independent imaging setting. BCBSMA believes that services such as MRI can be performed at

equal quality at lower cost settings. Due to higher unit cost at hospital settings, shifts in utilization distribution can have a material impact on cost.

BCBSMA is currently assessing strategies to address site of service cost differences by providing our members and providers with lower cost alternatives for high-quality imaging services.

Questions Regarding Provider Rate Negotiations

14) What factors do you consider when negotiating payment rates for inpatient care, facility charges for outpatient care, and physicians, and other professionals? Please explain each factor and rank them in the order of impact on negotiated rates.

BCBSMA Response

In preparation for and over the course of negotiations, BCBSMA uses many different information tools to assess the hospital's current and proposed reimbursement levels. These sources include but are not limited to:

- Hospital's audited financial statements, including hospital's 403 and 2553 cost reports;
- Peer group cost and rate analyses;
- Past claims experience and performance on quality programs; and
- Industry wide analyses and reports (Hewitt, as an example).

BCBSMA contracts with non-facility professional providers at the individual level and at the group level. This distinction is often dictated by the organizational structure of the providers in a given geographic location. Through these negotiations, BCBSMA works to solidify multi-year agreements that include performance measures focused on quality and efficiency improvements, with reimbursement rates determined relative to the value returned to our accounts and members. Some of the key data elements that are utilized in these negotiations are:

- Risk Adjusted Per Member Per Month total medical expense amounts as they compare to the overall network average;
- Performance on key quality metrics; and
- Reimbursement relativities to peer groups.

15) Is there a material difference in how you approach contracts when you are contracting with a health care system vs. contracting with organizations representing a single facility or provider group?

BCBSMA Response

Negotiating with providers that have a strong geographic presence, name or brand recognition, or specialty focus can present negotiating challenges. However, negotiations that are done at a health care system level present added opportunities as well. By negotiating at the system level, we can build programs, such as disease

management and case management that offer convenience and access for members. With larger systems, there are increased opportunities to develop meaningful and measurable performance metrics to increase the value of the contract to all parties. BCBSMA's goal in negotiating each contract with our providers is to deliver meaningful value to our customers through the aggressive negotiation of payment rates for units of service and through performance-based incentives.

16) We understand that certain systems demand higher rates because of geographic isolation, specialty practice and reputation. Please explain your understanding of this dynamic. Has this always been the case? Has this pattern changed over the past 10-20 years?

BCBSMA Response

In 1990, Massachusetts had 111 independent acute care hospitals whose payments were set by the state through a commission designed specifically for that purpose. Also, clinical practice was changing rapidly and care was moving from inpatient to outpatient settings. During the period that HMOs formed, not every hospital was in every health plan network. Taken together, these three factors created a situation where Massachusetts had more hospital beds than were required for the population and hospitals were actively competing for patients. With this increased competition for increased hospital beds, payers generally experienced lower payments.

The landscape has changed dramatically. Hospital mergers and closings have left approximately 70 hospitals, and many physicians have joined with each other to form Independent Physician Associations (IPAs), or with hospitals to form Physician-Hospital Organizations (PHOs) or other integrated delivery systems.

We have also observed that this consolidation has created new dynamics that are affecting health care cost and quality. While it might seem likely that consolidation of physicians and hospitals into large, integrated delivery systems would lead to better coordination and an opportunity for increased quality, current cost trends in Massachusetts have not yet reflected that. For example, the consolidation has resulted in some provider groups who have a stronger negotiating position with health plans because they either:

- Represent the only health care option in a given geographic area;
- Offer specialized care that cannot be delivered by other providers; or
- Enjoy such a strong reputation and patients demand access to their services.

As we negotiate with providers, we are aware of the priority our customers place on having broad access to the doctors and hospitals they prefer. In the environment mentioned above, providers have an advantage, knowing that the expectation from our customers is that we will keep all providers in our network. The result is higher payments to providers and thus higher premiums for all our members.

As payments to advantaged providers have increased, it has created an upward spiral of payments not just to these providers, but to other providers in our network, who argue

that without their own pay increases, they are not able to compete with the higher paid players in the market.

In addition, providers are seeking increases because of several other circumstances, including:

- Underpayment from Medicare and Medicaid;
- Need for capital investments; and
- High cost of living in Massachusetts, which leads to higher labor costs for doctors, nurses, and other health care workers.

All of these circumstances are compounded by nation-wide cost trends, including increasing use and intensity of services due to an aging population, the practice of defensive medicine, and the availability of costly new medications, procedures, and technologies.

Questions Regarding Possible Approaches to Mitigating Cost Growth

17) What actions is your organization currently undertaking that could slow the growth in premiums, including but not limited to alternative payment methods, provider network strategies, benefit designs and consumer information and incentives.
    a. What current factors limit your ability to execute these strategies or limit their effectiveness?
    b. What systemic or policy changes would allow you to carry out these strategies more effectively?
    c. What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently without reducing quality?

BCBSMA Response:

Slowing the growth in premiums is a key strategic priority for BCBSMA and we continue to undertake actions to address both components of premium; administrative costs to run our business (10%) and medical cost paid to providers (90%).

To lower our administrative costs we have taken steps to run our business more efficiently and effectively. Over a year ago, we launched an intensive effort to assess and bring about efficiencies across the organization. Results of this effort during 2009 included: consolidation of certain operational areas to avoid redundancies, restructuring our procurement process to lower costs, a freeze on pay for all BCBSMA associates, and no payments under the long-term incentive plan for senior executives.

Understanding that medical cost is the larger component of every premium dollar, we have taken a systematic approach in implementing strategies to address the various components of escalating medical trends; unit cost, utilization, provider mix and severity.

Some examples include:

- **Contracting and Incentives** – To manage unit cost, which contributes approximately 50% to our medical cost trend, we are focusing on various

contracting strategies. Our primary contracting model for addressing quality and affordability is the Alternative Quality Contract (AQC) and we are encouraged by the state's recommendation to adopt a similar payment model that moves away from the current fee-for-service system. For providers willing and able to participate in the AQC, we are working to minimize or eliminate fee-for-service rate increases. The goal of the AQC is to reduce medical expense trend by half over a five year contract term.

- **Network Changes** – We are also contracting with providers that offer needed services in lower-cost settings, such as limited services clinics and urgent care centers, and exploring the roles of online care, telemedicine, and e-visits. We recommend systematic or policy changes that would decrease the use of the emergency department for non-emergent conditions such as ear-aches and sore-throats by increasing the use of alternative settings such as urgent care centers and limited service clinics and would look to the state to strengthen its Determination of Need process to enhance competition and create a lower cost-point for these services.

- **Benefit Designs** – To lower costs, employers and members now appear willing to trade level of provider access, while retaining as much choice as possible. We have introduced benefit designs and plans such as tiered networks that encourage our members and their providers to use high-quality, lower-cost providers. We are also developing limited network plans. Such plans will provoke resistance from providers, and will need to offer savings while still offering sufficient access to a broad range of services to be attractive to employers. To enable plans to offer attractive, lower-cost products, greater regulatory flexibility on tiered networks, limited networks, and limited service areas is needed.

- **Quality Collaborations** – We are providing doctors and hospitals with data on the overuse, underuse and misuse of health care services and variations in practice patterns, cost and quality. Systematic standardization of reporting and methodology based on quality and cost will further these efforts. Our physician incentive programs now include measures that reward physicians for efficiency.

- **Care Management** – We also offer an integrated set of programs to improve our member's health and promote cost-effective care. To control the overuse of services we have programs to manage utilization and ensure members receive care based on evidence based guidelines. To manage the health of our members we offer an integrated solution that meets the needs of our members across the spectrum of health states: from wellness to chronic illness.

18) Could enhanced competition or government intervention or a combination of both mitigate the cost trends found in the Divisions report? Please describe the nature of the changes you would recommend. In addition, please address the following:

a. What would be the impact on your organization of making data public regarding quality and the reimbursement rates paid by each carrier to each hospital or system in a manner that identifies all relevant organizations? What is the advantage or disadvantage to your organization of the current confidential system?

BCBSMA Response:

Massachusetts is today a very competitive health care market, one of the few markets in the country with four large non-profit health plans. Routinely, the Massachusetts health plans are ranked in the top 10 nationally for quality, service and other measures of success according to national publication. Through the AQC and benefit design, BCBSMA is working to create more competition among providers. This competition, over time, will lead to moderated or reduced unit cost increases in the provider network.

BCBSMA supports increased transparency of payment rates to both consumers and providers as one of the levers to address rising health care cost trends. This increased transparency must be paired with both consumer and provider incentives to actively use the data to drive decision making.

Other Questions

19) Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

BCBSMA Response:

Additional cost drivers that we believe should be examined in subsequent years are:

a. Merged Market Reform: Health care reform mandated the merger of the individual and small group segments in Massachusetts effective July 2007. The individual segment has claims experience and trends that are significantly higher than the group business, due to higher morbidity and anti-selection in this segment. This has resulted in increasing per member per month trends across all services for the merged small group and individual segment by 4-5% and for the entire commercial group business by approximately 1-2%.

b. Overuse of medical services: Examples include increased rates of hospital admissions and emergency room visits for avoidable or ambulatory sensitive conditions, preventable readmissions, and increased use of orthopedic procedures related to hips, knees and backs.

c. Regulatory and legislative actions that impact costs and trends like mandates and assessments on insurers. Examples of recently implemented mandates that

resulted in increased costs are the recent assessments on a state level, as well as the expansion of the federal mental health parity law.

d. Cost shifting from public to private payers and the impact on commercial insured medical costs.

e. Environmental factors including but not limited to pandemics and the economic downturn.

20) Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

BCBSMA Response:

BCBSMA is committed to being a responsible steward of the valuable health care premiums entrusted to us. In this regard, we have taken steps to run our business more efficiently and effectively. A year ago, we launched an intensive effort to reduce our administrative costs and shrink the ten cents of every premium dollar it takes to run our business. This effort is centered on finding new efficiencies that will enable us to continue to fulfill our broader mission to our members, customers, and the community.

While these savings are important, we wish to emphasize that they only make a small dent in reducing the overall health care cost trend. That is because administrative costs make up only a small fraction of overall health care costs. Medical costs, including hospital costs, professional physician costs, ancillary provider costs and pharmacy on the other hand, make up fully 90 percent of every dollar of premium.

The real opportunity to lower health care costs is by working aggressively to lower medical costs. The solution to addressing affordability in health care must address the true cost drivers, which include increases in the cost per service, the shift from less expensive sites of service to more expensive sites of service, increases in the utilization and intensity of services.

Caps on health plan premiums, which are now being debated, irrationally approach the problem of health care costs by focusing on the result (insurance premiums) rather than the causes (underlying costs). This approach fails to recognize that premiums are tied to health care costs. A sustainable solution should focus on the drivers of costs and trends. A thoughtful solution will need to address utilization and severity increases due to the introduction and adoption of new technologies and treatments at higher costs with limited improvement in value, increases in discretionary services that are prone to overuse, shifting utilization towards higher cost settings, increased prevalence of chronic conditions and obesity, and an aging population.

BCBSMA is working to change the way we pay for health care service and reward the quality and efficiency – not quantity – of care our members receive. Our primary contracting model for addressing quality and affordability is the Alternative Quality Contract (AQC). The AQC combines two forms of payment: a global, or fixed, payment per patient adjusted for health status, which increases annually in line with inflation; and

substantial performance incentives tied to the latest nationally accepted measures of quality, effectiveness, and patient experience of care.

This new contract model is an important component of a needed overall strategy to align payment reform, performance measurement, provider and member incentives, and increased transparency of cost and quality information to achieve the twin goals of improving the quality AND affordability of health care for our members, providers and employers. Only then will the state achieve true health care cost reform.

Attorney General Questions

1) Please explain and submit a summary table showing the range of your relative commercial prices or payments from 2004-2008 for each acute care hospital and large physician group in Massachusetts (i.e., physicians who contract through a PHO, IPA, multi-specialty group, or other group arrangement).

BCBSMA Response:

Range of payments for Acute Care Hospitals paid on BCBSMA DRGs and Outpatient Fee Schedules

	All Products				All Products Blended IP/OP*	
	Inpatient		Outpatient			
	Low	High	Low	High	Low	High
FY04	1.00	2.03			1.00	2.03
FY05	1.00	2.16	1.00	1.86	1.00	1.99
FY06	1.00	1.92	1.00	1.87	1.00	1.89
FY07	1.00	1.93	1.00	1.77	1.00	1.84
FY08	1.00	1.92	1.00	1.72	1.00	1.80

Notes:
1.0 = lowest rate in network for that service category and that product
*2004 All products category is inpatient only

Range of payments for Large Physician Groups

	HMO/POS		PPO		Indemnity		All Products	
	Low	High	Low	High	Low	High	Low	High
FY04	1.00	2.18	1.00	1.86	1.00	2.01	1.00	2.02
FY05	1.00	2.39	1.00	2.55	1.00	2.76	1.00	2.57
FY06	1.00	2.91	1.00	2.91	1.00	2.91	1.00	2.91
FY07	1.00	3.18	1.00	3.18	1.00	3.18	1.00	3.18
FY08	1.00	3.30	1.00	3.30	1.00	3.30	1.00	3.30

Notes:
*1.0 = Network Fee Schedule
*All Product rate was determined by taking a straight average of the three multipliers

2) Please explain and submit supporting documents that show the results of any analysis you have done on the extent to which the range in your relative commercial prices for Massachusetts providers is correlated to: (1) the quality of care you have measured or tracked for the providers, (2) the sickness or complexity of the population being served, (3) the relative market position of the provider in your network, or (4) other factors that you have considered in negotiating and setting price or payment rates for providers.

BCBSMA Response:

BCBSMA does not have any specific analysis correlating relative commercial prices to the factors listed in this question. Our general approach to negotiating rates with non-facility providers is based on key data elements such as:

- Risk Adjusted Per Member Per Month total medical expense amounts as they compare to the overall network average (using DxCG health status adjustment);
- Performance on key quality metrics; and
- Reimbursement relativities to peer groups.

Our approach in hospital negotiations uses information tools including but not limited to:

- Hospital's audited financial statements, including hospital's 403 and 2553 cost reports;
- Peer group Cost and Rate analyses; and
- Past claims experience and performance on quality programs; and
- Industry wide analyses and reports (such as Hewitt).

BCBSMA continually evaluates the quality of health care our members receive. The science of performance measurement continues to evolve but is not yet sophisticated enough to correlate directly to the rates paid to providers. Many of our existing payment methodologies adjust for case mix and severity as part of base methodologies. BCBSMA was among the first in the nation to adopt the refined DRG inpatient payment methodology (APR-DRG).

3) Please explain and submit a summary table showing the range of health status-adjusted fully-loaded total medical expenses you paid on a per member per month basis from 2004 to 2008 for each Massachusetts provider in your network who contracts through a PHO, IPA, multi-specialty group, or other group arrangement, with each provider identified by whether it was paid on a global payment basis (i.e., any form of risk payment with a potential for a deficit beyond retention) or on a fee-for-service basis. "Fully-loaded" means inclusive of all administrative, medical management, and other supplemental payments, including but not limited to bonuses, grants, infrastructure funding, and reinsurance recoveries.

BCBSMA Response:

2008 Physician Efficiency
All Commercial HMO Risk Business
2008 estimate

Group	Relative Health Status Adjusted Total Medical Expense
Fee For Service Group 1	0.93
Global Payment Group 1	1.08
Fee For Service Group 2	0.93
Fee For Service Group 3	1.07
Fee For Service Group 4	0.99
Fee For Service Group 5	0.96
Fee For Service Group 6	0.95
Fee For Service Group 7	0.95
Fee For Service Group 8	1.33
Fee For Service Group 9	1.06
Fee For Service Group 10	0.96
Global Payment Group 2	0.95
Global Payment Group 3	0.91
Fee For Service Group 11	0.96
Fee For Service Group 12	0.89
Fee For Service Group 13	0.82
Fee For Service Group 14	0.88
Global Payment Group 4	0.97
Fee For Service Group 15	0.90
Fee For Service Group 16	1.00
Fee For Service Group 17	0.96
Fee For Service Group 18	1.05
Fee For Service Group 19	1.05
Fee For Service Group 20	1.10
Fee For Service Group 21	1.05
Fee For Service Group 22	0.80
Fee For Service Group 23	1.02
Fee For Service Group 24	0.81
Fee For Service Group 25	1.07
Fee For Service Group 26	0.95
Fee For Service Group 27	0.83
Fee For Service Group 28	0.91
Fee For Service Group 29	0.92
Fee For Service Group 30	0.97
Fee For Service Group 31	0.95
Fee For Service Group 32	0.91

4) Please explain and submit a summary table showing your premium trends from 2004 to 2008 with details on how much of your premium trend resulted from increases in administrative costs, reserve practices, and medical trend, including the proportion of medical trend that resulted from (1) health care provider unit price increases, (2) changes in utilization, and (3) all other factors, such as changes in mix of services, mix of location of services, member demographics, and plan design.

BCBSMA Response:

The table below summarizes the components of net premium pmpm trends from 2004 to 2008 for the Insured Commercial medical business.

Summary	2004	2005	2006	2007	2008
Unit Cost Trend	4.5%	7.3%	7.6%	6.9%	5.7%
Utilization Trend	4.7%	3.3%	2.8%	2.9%	2.5%
Severity trend	4.4%	3.1%	2.7%	2.8%	2.4%
Admin Trend	0.4%	0.1%	0.5%	1.0%	0.6%
CTR Trend	-0.3%	-0.2%	1.0%	0.8%	0.0%
All Other	-5.4%	-5.4%	-9.7%	-7.8%	-5.7%
Net Premium Trend	8.1%	7.9%	4.1%	6.1%	5.4%

Rating analysis for accounts renewing in the first quarter for each calendar have been used to develop components of premium.

Unit cost: This component of trend represents the increase in the cost of services. More specifically these are the annual increases for specific services, like an office visit or a hospital admission, most often negotiated with the providers of care. Drivers of the unit cost increases include the high cost of living and labor expenses, investments in e-technology, and cost shifting to private payers from public payer shortfalls.

Utilization trend: This component of trend can be defined as the increase in the number of services or units of service provided over a period of time. Examples of units of service are the number of inpatient admissions, number of office visits, Emergency room visits, lab or diagnostic services. Drivers of changes in the utilization of health care services include aging and deteriorating health status of the population and consumer demand for services. BCBSMA has implemented various chronic disease management, utilization management and care management programs over the past few years to address this trend.

Severity: This component of trend includes provider mix, which represents the shift in the setting where medical services are provided. The increase in the intensity of services provided is also included in this category. Increases in this component of trend result from services shifting from lower cost settings to higher cost settings. Drivers of provider mix include consumer demand, expansion of capacity in more expensive settings and physician practice patterns. Major drivers of changing intensity of services include provider adoption of new technology or services as well as consumer demand for those more expensive high tech services.

Administrative Expenses: The 10 cents of every premium dollar that covers administrative costs include salaries and benefits of our employees, technology investments, and a wide range of care management programs for our members. Blue Cross and Blue Shield of Massachusetts has continuously expanded and enhanced our wellness and disease management programs to improve the health of our members and the affordability of health care. Some components of administrative expenses such as broker commissions increase at the rate of premium.

Contribution to Reserves (CTR): The National Association of Insurance Commissioners has developed a metric called Risk Based Capital (RBC) to evaluate a company's reserves in light of its membership size and relative risk of its business. We manage our business to maintain RBC between 550-650% in accordance with parameters set by our Board of Directors. CTR targets include risk margins built into the premiums as protection to cover potential risks (operating, strategic, catastrophic, and regulatory). This component of premium also includes taxes (federal income tax and premium tax), where applicable. CTR's primarily increase at the rate of premium trend. In 2005, BCBSMA HMO Blue was exempted from paying federal income tax on income earned. This exemption is reflected in the low CTR increase in '05/'04. Other drivers of the change in CTR targets over time include changes in benefit distribution across the book of business, updates to the CTR levels based on projected risks and RBC levels, and the impact of strategic business decisions.

All other: This component includes the impact of changes in the mix of business including benefit buy-downs and demographics. This also includes the variance of actual components of premiums varying from projected pricing assumptions.

5) Please explain and submit supporting documents that show how your organization has considered steps to reduce the premium trend for small groups and large groups, including any analysis of alternative payment mechanisms for providers, and any limited-network or tiered products for consumers.

BCBSMA Response:

Slowing the growth in premiums is a key strategic priority for BCBSMA and we continue to undertake actions to address both components of premium; administrative costs to run our business (10%) and medical cost paid to providers (90%).

To lower our administrative costs we have taken steps to run our business more efficiently and effectively. Over a year ago, we launched an intensive effort to assess and bring about efficiencies across the organization. Results of this effort during 2009 included: consolidation of certain operational areas to avoid redundancies, restructuring our procurement process to lower costs, a freeze on pay for all BCBSMA associates, and no payments under the long-term incentive plan for senior executives.

Understanding that medical cost trend is the larger component of every premium dollar, we have taken a systematic approach in implementing strategies to address the various components of escalating medical trends; unit cost, utilization, provider mix and severity. Please also refer to our other answers herein.

Observed results from our efforts to reduce administrative (10%) and medical cost (90%) are passed on to our members and accounts through lower premiums or administrative fees.

6) Please explain and submit supporting documents that show how your organization has considered steps to reduce the range of relative prices and total medical expenses you pay to providers in Massachusetts, including any analysis of alternative payment mechanisms for providers, and any limited-network or tiered products for consumers.

BCBSMA Response:

BCBSMA has taken a systematic approach to reduce the range of relative prices and total medical expenses paid to providers. To this end, we have undertaken strategies to address the various components of escalating medical trends; unit cost, utilization, provider mix and severity. Some examples include:

- **Contracting and Incentives** – To manage unit cost, which contributes approximately 50% to our medical cost trend, we are focusing on various contracting strategies. Our primary contracting model for addressing quality and affordability is the Alternative Quality Contract (AQC) and we are encouraged by the state's recommendation to adopt a similar payment model that moves away from the current fee-for-service system. For providers willing and able to participate in the AQC, we are working to minimize or eliminate fee-for-service rate increases. The goal of the AQC is to reduce the medical expense trend by half over a five year contract.

- **Network Changes** – We are also contracting with providers that offer needed services in lower-cost settings, such as limited services clinics and urgent care centers, and exploring the roles of online care, telemedicine, and e-visits. We recommend systematic or policy changes that would decrease the use of the emergency department for non-emergent conditions such as ear-aches and sore-throats by increasing the use of alternative settings such as urgent care centers and limited service clinics and would look to the state to strengthen its Determination of Need process to enhance competition and create a lower cost-point for these services.

- **Benefit Designs** – To lower costs, employers and members now appear willing to trade level of provider access, while retaining as much choice as possible. We are offering benefit designs and plans such as tiered networks that encourage our members and their providers to use high-quality, lower-cost providers. We are also developing limited network plans. Such plans will provoke resistance from providers, and will need to offer savings while still offering sufficient access to a broad range of services to be attractive to employers. To enable plans to offer attractive, lower-cost products, greater regulatory flexibility on tiered networks, limited networks, and limited service areas is needed.

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End of Responses

I affirm that the facts contained in the preceding response are true to the best of my knowledge. This document is signed under the penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that facts stated with respect to such matters are true.

Sincerely,

John J. Curley, Jr.